



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

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## MEMORANDUM

**DATE:** November 8, 2005

**TO:** Long Term Care Facilities

**FROM:** MDCH/Clinical Advisory Panel  
Quality Improvement Nurse Consultants

**RE:** Process Guideline for Altered Nutritional Status

### Overview

Best clinical practice is only worthwhile to the extent that we use it to guide care for our residents.

Collaboratively, we are striving to improve the nutritional status of nursing home residents in Michigan. The purpose of the Guide is to clarify how to apply the **Documentation Checklist: Process Guideline for Altered Nutritional Status.** Electronic copies are available for reprint at [www.michigan.gov/qinc](http://www.michigan.gov/qinc) . Click on the Best Practices once you've reached the website.

This optional "best practice" tool was presented to you at the Fall 2005 Joint Provider/Surveyor Training on October 25, 2005. Effective date for usage of the tool will be **November 8, 2005**. Both facilities and surveyors will have the opportunity to use the Documentation Checklist when a resident's nutritional status is a concern. Facilities will be accorded the opportunity to demonstrate that they have followed the steps in this guideline, as evidence to support an appropriate care process related to preventing and managing an altered nutritional status.

A workgroup including doctors, nurses, a nursing assistant, dieticians, a dietary manager, and a pharmacist discussed geriatric nutrition in depth. They used generally accepted, current references about geriatric nutrition to help prepare the Process Guideline. The Documentation Checklist contains a series of steps related to preventing and managing an altered nutritional status.

Best clinical practice information helps each facility provide the best possible care throughout the year. Along with information in the Federal OBRA regulations, our surveyors will use these Process Guidelines to review how your facility is managing nutritional concerns. We encourage you to examine your process to prevent and manage altered resident nutrition and to consider the application of the following information.

### **The Basic Care Process**

The management of all conditions and problems in a nursing home should follow the steps included in the basic care process. We have utilized the terminology **staff and practitioner** throughout the guideline to designate responsibility for care. For the purpose of clarification the term **practitioner refers to a physician or their designee** (e.g. physician assistant, clinical nurse practitioner, etc.) **that has the authority to write medical “orders.”**

Assessment/recognition. The purpose of this step is to provide a rational basis for deciding whether there is a need, risk, or problem and what to do about it. The facility’s staff and practitioners collect relevant information about resident (history, signs and symptoms, known medical conditions, personal habits, and patterns, etc.) and then a) evaluate and organize that information to identify whether the individual has a specific need, condition, or problem; and b) describe and define the nature (onset, duration, frequency, etc.) of the risk, condition, or problem.

Diagnosis/cause identification. The facility’s staff and practitioners attempt to identify causes of a condition or problem, or explain why causes cannot or should not be identified.

Treatment/management. The facility’s staff and practitioners use the above information to decide how to manage a resident’s condition, symptom, or situation. Where causes may be identifiable and correctable, they seek and address them or explain why they could or should not have done so.

Monitoring. The facility’s staff and practitioners evaluate the individual’s progress over time in relation to a risk, need, problem, condition, or symptom; consider the effectiveness of interventions; and make a systematic determination about what to do next.